

Physician-Focused Payment Model Technical Advisory Committee

Committee Members

Jeffrey Bailet, MD, *Chair*
Grace Terrell, MD, MMM
Vice Chair
Paul N. Casale, MD, MPH
Tim Ferris, MD, MPH
Rhonda M. Medows, MD
Harold D. Miller
Len M. Nichols, PhD
Kavita Patel, MD, MSHS
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Bruce Steinwald, MBA
Jennifer Wiler, MD, MBA

January 29, 2019

Alex M. Azar II, Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Secretary Azar:

On behalf of the Physician-Focused Payment Model Technical Advisory Committee (PTAC), I am pleased to submit PTAC's comments and recommendation to you on a physician-focused payment model (PFPM), *Making Accountable Sustainable Oncology Networks (MASON)*, submitted by Innovative Oncology Business Solutions Inc. These comments and recommendation are required by section 1868(c) of the Social Security Act, which directs PTAC to 1) review PFPM models submitted to PTAC by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary.

With the assistance of HHS' Office of the Assistant Secretary for Planning and Evaluation (ASPE), PTAC's members carefully reviewed the *MASON* proposal (submitted to PTAC on February 18, 2018); additional information on the model, which was provided by the submitter in response to questions from a PTAC Preliminary Review Team; and other information. At a public meeting of PTAC held on December 10, 2018, the Committee deliberated on the extent to which this proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended.

PTAC recommends Innovative Oncology Business Solutions Inc.'s proposal to the Secretary for further development and implementation as a payment model as specified in PTAC comments. The Committee finds that the proposal meets all ten of the Secretary's criteria and deserves priority consideration based on the scope and health information technology criteria. PTAC commends the proposal's granular and flexible approach to cancer payment, with payment levels specific to conditions and treatment pathways. The Committee also lauds the proposal's inclusiveness, beginning at the time of diagnosis and accommodating a variety of treatments and stages. PTAC offers recommendations for evaluating the methodological innovations and engaging providers, both of which PTAC stresses are critical for this proposal to be successfully developed and implemented as recommended. Ultimately, PTAC found this proposal to be a thoughtful and significant response to the potential for

and challenges of incorporating the principles of alternative payment models (APMs) into how cancer care is delivered and reimbursed.

The members of PTAC appreciate your support of our shared goal of improving the Medicare program for both beneficiaries and the physicians who care for them. The Committee looks forward to your detailed response. If you need additional information, please have your staff contact me at Jeff.Bailet@blueshieldca.com.

Sincerely,

//Jeffrey Bailet, MD//

Jeffrey Bailet, MD

Chair

Attachments

REPORT TO THE SECRETARY OF HEALTH AND HUMAN SERVICES

Comments and Recommendation on

Making Accountable Sustainable Oncology Networks (MASON)

January 29, 2019

About This Report

The Physician-Focused Payment Model Technical Advisory Committee (PTAC) was established by the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) to 1) review physician-focused payment models (PFPMs) submitted by individuals and stakeholder entities, 2) prepare comments and recommendations regarding whether such models meet criteria established by the Secretary of Health and Human Services (HHS), and 3) submit these comments and recommendations to the Secretary. PTAC reviews submitted proposals using criteria established by the Secretary in regulations at 42 CFR § 414.1465.

This report contains PTAC's comments and recommendation on the PFPM proposal *Making Accountable Sustainable Oncology Networks (MASON)*. This report also includes: 1) a summary of PTAC's review of the proposal; 2) a summary of the proposed model; 3) PTAC's comments on the proposed model and its recommendation to the Secretary; and 4) PTAC's evaluation of the proposed PFPM against each of the Secretary's criteria for PFPMs. The appendices to this report include a record of the voting by PTAC on this proposal, the proposal submitted by Innovative Oncology Business Solutions Inc., and additional information on the proposal submitted subsequent to the initial proposal submission.

SUMMARY STATEMENT

PTAC recommends the *Making Accountable Sustainable Oncology Networks (MASON)* proposal to the Secretary for further development and implementation as a payment model as specified in PTAC's comments. PTAC finds that the proposal meets all of the Secretary's criteria for physician-focused payment models and deserves priority consideration based on the scope and health information technology criteria. The Committee concludes that the proposed model (which ties payment to diagnosis and uses "target prices" specific to an individual's disease state, comorbidities, and treatment plan) would help to substantially improve the way that the Medicare program pays for cancer care by creating a more granular and flexible approach to cancer payment.

PTAC affirms both the need for and the challenges associated with a more precise approach to cancer payment that reflects the nuance in treatment based on complexity. Although the *MASON* proposal's process for setting "target prices" is novel and complex, the submitter's description of the evidence for these methods at the public meeting allayed concerns about feasibility. In support of PTAC's broader recommendation for development and implementation of this proposal, PTAC urges exploration and validation of the methods involved in constructing the payment model, as well as attention to securing the engagement of the broader oncologist community that may be less amenable to taking on financial risk and the practice transformation required to participate in this type of payment arrangement.

PTAC REVIEW OF THE PROPOSAL

The *MASON* proposal was submitted to PTAC on February 18, 2018. The proposal was first reviewed by a Preliminary Review Team (PRT) composed of three PTAC members (Grace Terrell MD; Robert Berenson MD; and Bruce Steinwald). The PRT conducted its review of the revised proposal between April 4, 2018, and October 1, 2018. The proposal was also posted for public comment. In addition, the Bipartisan Budget Act of 2018 allows for initial feedback to submitters of proposed models on the extent to which their proposal meets the Secretary's criteria and the basis for that feedback. The PRT sent initial feedback on the proposed model to the submitter on July 30, 2018. The PRT's findings were documented in the PRT Report to the PTAC on the *Making Accountable Sustainable Oncology Networks* proposal dated October 3, 2018. At a public meeting held on December 10, 2018, PTAC deliberated on the extent to which the proposal meets the criteria established by the Secretary in regulations at 42 CFR §414.1465 and whether it should be recommended to the Secretary for implementation.¹ The submitter

¹PTAC members Tim Ferris, MD, MPH, and Rhonda Medows, MD, were not in attendance. PTAC member Harold Miller recused himself from deliberation and voting on this proposal. PTAC member Kavita Patel, MD, MSHS, was not in attendance and recused herself from deliberation and voting on this proposal.

and members of the public were given an opportunity to make statements to the Committee at the public meeting. Below are a summary of the proposal, PTAC's comments and recommendation to the Secretary on the proposal, and the results of PTAC's evaluation of the proposal using the Secretary's criteria for PFPMs.

PROPOSAL SUMMARY

The proposal is for a pilot program involving 16 oncology practices that compose the National Cancer Care Alliance (NCCA). The proposed model consists of a prescribed *care* model with a specified infrastructure to support oncology practice transformation, combined with a *payment* model to support infrastructure costs and incentivize adherence to evidence-based care pathways.

The care model would require use of clinical pathways that are updated by NCCA physicians and reflect the consensus for the latest evidence-based care; a cognitive computing platform that codifies the pathways; and machine learning and big data techniques that identify natural breakpoints in the Medicare claims data and correlate those subsets with the clinical characteristics of the patients obtained from the electronic health records (EHRs).

This care model infrastructure supports the generation of Oncology Payment Categories (OPCs), which group patients based on disease state, comorbidities, and treatment plan. A target price based on the expected costs of caring for patients in a given OPC would be assigned. OPCs have not yet been developed but are modeled after the Centers for Medicare & Medicaid Services's (CMS's) Ambulatory Payment Classification for care delivered in the outpatient hospital setting. They will be generated using machine learning algorithms and a cognitive computing infrastructure. At the public meeting at which this proposal was reviewed, the submitter presented information on the approach to generating OPCs using 2,500 observations of patients with breast cancer.

The OPCs are generated from a combination of claims data and EHR data using a cognitive computing platform and big data techniques. The first step in generating the OPCs is to identify "clusters" of patients based on their claims data with the same tumor type and similar clinical characteristics (as identified in the EHR data). Appropriate utilization for each cluster will be identified based on the evidence-based pathways and used to define the target price for each OPC. The OPCs will be refined over time using cognitive computing techniques to reflect changes in treatment guidelines and new therapies. As the sample size of patients in the proposed model grows, OPCs may also be modified to reflect additional insight into how patients are clustered; for example, additional observations could prompt a single OPC being split into two OPCs.

The OPCs are described in the proposal as “in essence a mini-bundle.” The OPC target price is designed to reflect almost all cancer care-related expenses. It includes evaluation and management (E&M) visits, a one-time \$750 payment for new patient consultation, infusion center facility fees, variable radiation and infusion inputs, hospital charges and facility fees, other physician care related to the cancer treatment, imaging, and laboratory services. However, all drugs, including parenteral and oral chemotherapy, are excluded from the OPC target amount. Further, while Hierarchical Condition Categories (HCCs) and the variation in cost due to comorbidities are recognized, claims related to pre-existing diagnoses are not included in the OPC.

In this proposed model, an episode is initiated upon first consultation with an oncologist. Relevant clinical factors and patient preferences will be used to select a treatment plan and broader care plan, resulting in the categorization of the patient into an OPC and an assigned OPC target price.

OPC assignment prompts creation of a “virtual account,” visible to both providers and patients, that tracks cancer care claims and expenditures in real time against the target amount, including care received from external providers. If patients are managed in a way that reduces their expenditures below the target amount, the participating practice shares in these savings if quality benchmarks are sufficiently met. The proposed model also relies on a reinsurance mechanism that covers expenses over the target amount.

Services would be paid in a fee-for-service (FFS) manner, with retrospective reconciliation. There is a withhold of 4 percent from all E&M payments to form a quality pool.

Quality metrics reflect two components, defined as technical quality and customer service quality. Technical quality is measured via pathway compliance, which is extracted electronically from the EHR and is based on adherence to the pathways. Customer service quality is captured via patient and family surveys. For both measures, a threshold of 80 percent is required to be considered satisfactory.

RECOMMENDATION AND COMMENTS TO THE SECRETARY

PTAC recommends the *MASON* proposal to the Secretary for further development and implementation as a payment model as specified in our comments below. PTAC finds this proposal to be a thoughtful response to the potential for and challenges of incorporating the principles of alternative payment models into how cancer care is delivered and reimbursed. Furthermore, the Committee believes it is highly responsive to the CMMI request for information (RFI) emphasizing small-scale testing of payment interventions. PTAC found a number of aspects of the proposal appealing, specifically: 1) the initiation of the proposed model at the time of diagnosis, 2) the specificity of the target payment amounts to the disease

state and other factors likely to affect utilization, and 3) the proposed model's grounding in evidence-based care pathways. The proposed model acknowledges the very granular and individualized nature of treatment plans for different types of cancer by using the evidence-based care pathways as the basis for establishing the target payment amounts. The proposed model is not based on a predefined time frame, but rather the episode length reflects the specific disease and the care plan selected. By positioning the proposed model to initiate at the time of diagnosis and cover a variety of treatment plans, *MASON* is inclusive of patients and conditions for which chemotherapy is not the most appropriate course of action. PTAC acknowledges the importance of the Center of Medicare & Medicaid Innovation's (CMMI's) current Oncology Care Model (OCM) and believes that the *MASON* proposal could significantly strengthen the OCM model.

The *MASON* proposal relies on the development of the OPCs, a process which is methodologically complex and novel. The submitter did present evidence that their approach is feasible, talking through an application of the OPC methodology to sample data for 2,500 patients with breast cancer. PTAC believes that further testing and validation should be conducted by CMMI to verify the methods described in the proposal, particularly as this evidence was provided after the PRT Report to the full Committee and thus did not factor into their in-depth review. This process should include attention to the sample sizes required for OPC generation and updating, the computing time entailed in such endeavors, how frequently OPCs may need to be modified to stay current, and how to account for OPC updating for participants already engaged in *MASON*. Similarly, additional examination is recommended to confirm which, if any, of the methods used to develop the OPCs are proprietary. Although the submitter indicated that the analytical methodologies are open-source, there was mention of big data applications and processing techniques that may be proprietary and were described as important for the timely development of the OPCs. To this end, one PTAC member suggested the potential for a competitive marketplace for this component as a way to maximize the accessibility and efficiency of this type of precision approach to cancer care.

PTAC views this model's reliance on both claims and clinical data as a challenge to its scalability. Ultimately, some members believe that developing stronger alternative payment models (APMs) will require CMS to develop the infrastructure for collecting and evaluating these kinds of clinical data. PTAC believes that timely collection of clinical data on a large enough sample is essential for designing payment models that are tailored to the complexity of different conditions. In this case, the type of granular cancer model advocated in the proposal would require additional clinical data that CMS does not currently collect, such as the EHR data used for OPC generation and assignment. Cancer is well suited as a clinical prototype for exploring how CMMI can develop this data infrastructure.

PTAC concludes that the proposed model represents a potential paradigm shift in how cancer care is delivered and reimbursed but also cautions that the magnitude of both the behind-the-

scenes methodological innovations and the on-the-ground delivery transformation should not be underestimated. Development and implementation of the *MASON* model, as recommended by PTAC, will require diligent collaboration with the submitter and the broader provider community. For the proposed model to be successfully implemented and scaled, there must be thoughtful outreach to the providers who may eventually be incorporating this model into their practice style. While the demonstration has the enthusiastic support of the 16 NCCA practices, these practices may not be representative of the broader provider community. Thus, PTAC recommends that a strategy be developed for securing the support and facilitating the success of practices who may be more hesitant to take on risk and disrupt their patterns of care delivery under this model.

PTAC is aware that CMMI is currently testing a model in this space, so it is possible that the considerations mentioned here may be underway. Preceded by Hackensack Meridian Health and Cota Inc.'s "Oncology Bundled Payment Program Using CNA-Guided Care," the *MASON* proposal represents the second sophisticated and thoughtful proposal reviewed and recommended by PTAC to create a more granular and flexible approach to cancer payment.

EVALUATION OF PROPOSAL USING SECRETARY'S CRITERIA

PTAC Rating of Proposal by Secretarial Criteria

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Rating
1. Scope (High Priority)	Meets and Deserves Priority Consideration
2. Quality and Cost (High Priority)	Meets
3. Payment Methodology (High Priority)	Meets
4. Value over Volume	Meets
5. Flexibility	Meets
6. Ability to Be Evaluated	Meets
7. Integration and Care Coordination	Meets
8. Patient Choice	Meets
9. Patient Safety	Meets
10. Health Information Technology	Meets and Deserves Priority Consideration

Criterion 1. Scope (High-Priority Criterion)

Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.

Rating: Meets and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. While the CMS APM portfolio already includes a model addressing the proposal's clinical area (cancer) and provider entities (oncologists) via the OCM, the proposed model potentially builds on the OCM, broadening its scope and introducing a more individualized approach to payment levels. Namely, the proposed model acknowledges the very granular and individualized nature of treatment plans for different types of cancer, and the payment model reflects this precision by using evidence-based pathways as the basis for establishing payment amounts. The proposed model is not based on a predefined time frame, but rather the episode length reflects the specific disease and the care plan selected. By positioning the proposed model to initiate at the time of diagnosis and cover a variety of treatment plans, *MASON* is inclusive of patients and conditions for which chemotherapy is not the most appropriate course of action. Finally, the payment model attempts to hold oncologists accountable only for cancer-related expenditures, rather than Total Cost of Care (TCoC).

Criterion 2. Quality and Cost (High-Priority Criterion)

Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. In terms of quality, using evidence-based treatment pathways and measuring and rewarding clinical quality based on adherence to these pathways is a clear strength of the proposal and would be expected to improve the quality of care. The use of these treatment pathways will strengthen the generalizability of the OPCs beyond the select group of practices piloting *MASON*. Given how dynamic the oncology field is, with evolving clinical guidelines and frequent introduction of new therapies, the machine learning methodology described in the proposal is critical for the accuracy and agility of the proposed model and its ability to both reclassify patients as the model matures or new treatment recommendations are issued, as well as adjust target prices that reflect current but rapidly evolving standards of care.

PTAC also questioned how the OPC target prices would be established since (as discussed under Criterion 3) the OPCs are not currently operational.

Criterion 3. Payment Methodology (High-Priority Criterion)

Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the PFPM cannot be tested under current payment methodologies.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. A strength of this proposal is the payment model's attention to care coordination and other medical home activities utilized throughout a patient's care trajectory. An additional strength of the payment model is its choice to base payment on cancer-related care rather than TCoC, thereby holding participating providers accountable only for utilization of care that is under their direct influence. A further strength is the inclusion of an administrative fee related to drug purchasing and administration. PTAC endorses the submitter's revision of this fee to a flat rate rather than a percentage of the drug price.

The Committee has some concerns with the payment model related to the OPCs, the building blocks of the *MASON* payment model, which are not fully developed. By setting target prices for patients based on their diagnosis, comorbidities, and treatment pathway, the OPCs are conceptually appealing in that they are specific to the patient's clinical characteristics and also only hold participating providers responsible for cancer-related care. This kind of granularity is due to innovative machine learning techniques and a cognitive computing platform that represent a new way of identifying utilization trends in claims data and assigning pricing benchmarks. While the novelty of these methods is laudable, the fact that OPC development has not actually been completed gives PTAC pause. In addition to concerns about the initial development of the OPCs and how target process would be established, PTAC also has questions about how the OPCs would be updated to keep up with the pace of advances in cancer therapy. Cancer treatment is a rapidly evolving field, and for the proposed payment model to incentivize value-based care that reflects current guidelines, it must have a similar agility. Thus, the process required for updating OPCs, and how such updates are disseminated to participating practices and incorporated into patient care plans, are critical implementation issues that merit consideration during the development process.

With respect to these concerns, during PTAC's public deliberation on the *MASON* proposal, the submitter presented an example (using a small sample of data on breast cancer patients) of how OPCs could be developed and spoke briefly about how advanced data processing techniques could be used to produce updates relatively quickly. While this discussion was sufficient to allay PTAC's initial hesitation, the Committee recommends further review and validation of the OPC development algorithms by CMS. Such review should, among other

considerations, examine the time required for OPC development and updating, as well as the process for delineating cancer-related expenditures.

Criterion 4. Value over Volume

Provide incentives to practitioners to deliver high-quality health care.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The review of the virtual accounts by providers and patients, as well as the process of identifying providers delivering low-value care, as captured by pathway deviations and other metrics, is compelling and likely to improve the value of cancer care. Nonetheless, the payment model challenges addressed in the previous criteria will need to be addressed in order to fully realize the proposed model's potential to improve value.

A particular implementation challenge will be isolating cancer care expenditures from expenditures for other conditions in generating the OPCs. Holding providers accountable for cancer care-related costs, as opposed to TCoC, is appealing but may be challenging to execute, and accurate classification of cancer care related costs versus other costs is critical for realizing the notion of "value over volume." Another potential challenge is the agility with which the OPCs can be updated based on advances in cancer care. Ideally, updates would occur quickly after new practice guidelines are adopted, to allow for the OPCs to keep pace with the latest treatment recommendations and new therapies in order to fully reflect the most current definition of what represents "value" in cancer care.

Criterion 5. Flexibility

Provide the flexibility needed for practitioners to deliver high-quality health care.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The combination of the evidence-based pathways and a process for accommodating deviations from those pathways balances the need for incentivizing high-quality care while also allowing for physician autonomy in tailoring that care. For example, if the physician enters a treatment into the EHR that is not deemed "on pathway," the EHR prompts the physician with this information, and the physician has an opportunity to justify why this treatment is an appropriate course of action.

However, the proposed model would benefit from a more nuanced process for accommodating such deviations in the quality measurement process—i.e., it was not clear how justifications for going off-pathway would be factored into the quality scoring process to avoid penalizing practices for appropriate deviations. If unaddressed, this could create misalignment between

the provider’s best clinical judgment and the proposed model’s financial incentives and may deter providers from participating if they perceive *MASON* to be too “cookbook” in nature.

Criterion 6. Ability to Be Evaluated

Have evaluable goals for quality of care, cost, and any other goals of the PFPM.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The proposed model specifies metrics for capturing quality of care, cost, and patient satisfaction. The proposal identified Innovative Oncology Business Solutions Inc. as the evaluator, and PTAC raised concerns at the public deliberation about the same organization overseeing *MASON* and evaluating it. At that time, the submitter articulated a preference for an external evaluator, and PTAC endorses a separate evaluation infrastructure as part of the development and implementation of the proposed model.

Criterion 7. Integration and Care Coordination

Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. Notably, the proposed model encompasses more than just the time period a patient is undergoing chemotherapy, as reflected in aspects such as how an episode is defined and the direct incentives around care coordination that are not linked with a specific treatment approach. Furthermore, this model is inclusive of independent practice physicians, rather than being designed with integrated health systems in mind.

One concern is that the proposed model’s effort to delineate cancer and non-cancer care may disincentivize care coordination beyond the core team of cancer care providers, a potential problem in a Medicare population in which cancer occurs in individuals who often have multiple chronic conditions. Furthermore, the emphasis on spending, and granular detail on spending that is available to participating entities, may inhibit integration and coordination: specifically, the possible exclusion of high-spending clinicians may not necessarily generate the highest-quality team. High-cost physicians are sometimes high cost because the most complex patients go to them, and so the implications of identifying a provider as a high-cost provider must be carefully thought through and unintended consequences prevented.

Criterion 8. Patient Choice

Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. It is explicitly stated that patient preferences for providers and hospitals will be solicited and accommodated “as much as possible.” Furthermore, the proposal briefly describes a patient “app” that will facilitate timelier and more direct patient-initiated communication with the clinical team.

However, the proposed model would benefit from a more robust and detailed plan for shared decision-making, especially given the importance of patient preferences at many decision points in a cancer care trajectory, such as chemotherapy initiation near the end of life. Attention will also need to be given to the ease of changing OPCs due to a change in care plan or disease status. This may inhibit patient choice if it delays a patient’s desired changes in their care plan.

In addition, the process for and implications of patients exiting *MASON* were not fully described and could introduce unintended incentives to disenroll patients who are relatively more expensive within a given OPC. This issue may be compounded in the absence of streamlined distinctions between cancer and non-cancer care.

Criterion 9. Patient Safety

Aim to maintain or improve standards of patient safety.

Rating: Meets

PTAC concludes that the proposed model meets this criterion. The evidence-based care pathways are likely to yield improvements in patient safety to the extent that they steer providers to care regimens that reflect the latest evidence and guidelines on safety of care. The data capture supporting these pathways and their quality compliance metric is also intended to facilitate monitoring that, in theory, can support patient safety goals. The transparency and detail of the virtual accounts, which will include data on providers both in and out of the APM entity practice, offers additional visibility that could improve patient safety to the extent that it is used to evaluate collaborating providers.

Criterion 10. Health Information Technology

Encourage use of health information technology to inform care.

Rating: Meets and Deserves Priority Consideration

PTAC concludes that the proposed model meets this criterion and deserves priority consideration. This proposal employs health information technology in a variety of innovative ways to both support the proposed model's infrastructure and facilitate its ongoing operation. The machine learning and cognitive computing platform are vital to the development and updating of the OPCs, and participating practices in the pilot version of this proposal will all therefore be advanced users of EHRs. The virtual accounts are another technological backbone of the proposed model, allowing real-time access to claims and expenditures for both providers and patients, though on this point there was a lack of detail as to the interoperability of systems across participating providers.

APPENDIX 1. COMMITTEE MEMBERS AND TERMS

Jeffrey Bailet, MD, Chair

Grace Terrell, MD, MMM, Vice Chair

Term Expires October 2019

Paul N. Casale, MD, MPH
New York Quality Care
New York-Presbyterian, Columbia University
College of Physicians and Surgeons, Weill
Cornell Medicine
New York, NY

Bruce Steinwald, MBA
Independent Consultant
Washington, DC

Tim Ferris, MD, MPH
Massachusetts General Physicians
Organization
Boston, MA

Term Expires October 2020

Rhonda M. Medows, MD
Providence St. Joseph Health
Seattle, WA

Len M. Nichols, PhD
Center for Health Policy Research and Ethics
George Mason University
Fairfax, VA

Harold D. Miller
Center for Healthcare Quality and Payment
Reform
Pittsburgh, PA

Grace Terrell, MD, MMM
Envision Genomics
Huntsville, AL

Term Expires October 2021

Jeffrey Bailet, MD
Blue Shield of California
San Francisco, CA

Angelo Sinopoli, MD
Prisma Health
Greenville, SC

Kavita Patel, MD, MSHS
Johns Hopkins Health System
Baltimore, MD

Jennifer Wiler, MD, MBA
University of Colorado School of Medicine
Aurora, CO

APPENDIX 2. PFPM CRITERIA ESTABLISHED BY THE SECRETARY

PFPM CRITERIA ESTABLISHED BY THE SECRETARY

- 1. Scope.** Aim to either directly address an issue in payment policy that broadens and expands the CMS APM portfolio or include APM Entities whose opportunities to participate in APMs have been limited.
- 2. Quality and Cost.** Are anticipated to improve health care quality at no additional cost, maintain health care quality while decreasing cost, or both improve health care quality and decrease cost.
- 3. Payment Methodology.** Pay APM Entities with a payment methodology designed to achieve the goals of the PFPM criteria. Addresses in detail through this methodology how Medicare and other payers, if applicable, pay APM Entities, how the payment methodology differs from current payment methodologies, and why the Physician-Focused Payment Model cannot be tested under current payment methodologies.
- 4. Value over Volume.** Provide incentives to practitioners to deliver high-quality health care.
- 5. Flexibility.** Provide the flexibility needed for practitioners to deliver high-quality health care.
- 6. Ability to be Evaluated.** Have evaluable goals for quality of care, cost, and any other goals of the PFPM.
- 7. Integration and Care Coordination.** Encourage greater integration and care coordination among practitioners and across settings where multiple practitioners or settings are relevant to delivering care to the population treated under the PFPM.
- 8. Patient Choice.** Encourage greater attention to the health of the population served while also supporting the unique needs and preferences of individual patients.
- 9. Patient Safety.** Aim to maintain or improve standards of patient safety.
- 10. Health Information Technology.** Encourage use of health information technology to inform care.

APPENDIX 3. DISTRIBUTION OF MEMBER VOTES ON EXTENT TO WHICH PROPOSAL MEETS CRITERIA¹

Criteria Specified by the Secretary (at 42 CFR §414.1465)	Not Applicable	Does Not Meet Criterion		Meets Criterion		Priority Consideration		Rating
	*	1	2	3	4	5	6	
1. Scope (High Priority) ²	0	0	0	0	2	0	5	Priority Consideration
2. Quality and Cost (High Priority)	0	0	0	4	2	1	0	Meets
3. Payment Methodology (High Priority)	0	0	2	4	1	0	0	Meets
4. Value over Volume	0	0	0	3	3	0	1	Meets
5. Flexibility	0	0	0	2	4	1	0	Meets
6. Ability to Be Evaluated	0	0	0	3	2	1	1	Meets
7. Integration and Care Coordination	0	0	0	4	3	0	0	Meets
8. Patient Choice	0	0	0	2	3	1	1	Meets
9. Patient Safety	0	0	0	1	4	1	1	Meets
10. Health Information Technology	0	0	0	0	3	1	3	Priority Consideration

¹PTAC members Tim Ferris, MD, MPH, and Rhonda Medows, MD, were not in attendance. PTAC member Harold Miller recused himself from deliberation and voting on this proposal. PTAC member Kavita Patel, MD, MSHS, was not in attendance and recused herself from deliberation and voting on this proposal.

²Criteria designated as “high priority” are those PTAC believes are of greatest importance in the overall review of the payment model proposal.

APPENDIX 4. DISTRIBUTION OF MEMBER VOTES ON RECOMMENDATION¹

Recommendation Vote: Part 1²

Not Recommended for Implementation as a PFPM	Recommended	Referred for Other Attention by HHS	Result
0	7	0	Recommended

Recommendation Vote: Part 2 (if applicable)

Proposal substantially meets Secretary's criteria for PFPMs. PTAC recommends implementing proposal as a payment model.	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.	PTAC recommends testing the proposal as specified in PTAC comments to inform payment model development.	PTAC recommends implementing the proposal as part of an existing or planned CMMI model.	Result
0	6	1	0	PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.

Final recommendation to the Secretary: PTAC recommends further developing and implementing the proposal as a payment model as specified in PTAC comments.

¹PTAC members Tim Ferris, MD, MPH, and Rhonda Medows, MD, were not in attendance. PTAC member Harold Miller recused himself from deliberation and voting on this proposal. PTAC member Kavita Patel, MD, MSHS, was not in attendance and recused herself from deliberation and voting on this proposal.

²In 2018, PTAC adopted new recommendation categories, used first at their December 2018 public meeting. PTAC votes on the proposal using the following three categories: 1) not recommended for implementation as a PFPM, 2) recommended, and 3) referred for other attention by HHS. If a two-thirds majority votes to not recommend the proposal, then that is the final recommendation to the Secretary. The same is true if a two-thirds majority votes to refer the proposal for other attention by HHS. If a two-thirds majority votes to recommend the proposal, PTAC proceeds to vote on the proposal using four recommendation subcategories. A two-thirds majority determines the final recommendation.